



Texas Department of Insurance

Division of Workers' Compensation

Medical Fee Dispute Resolution, MS-48

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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

TEXAS HEALTH PLANO
3255 WEST PIONEER PARKWAY
ARLINGTON TX 76013

Respondent Name

Hartford Accident & Indemnity

Carrier's Austin Representative Box

Box Number 47

MFDR Tracking Number

M4-13-2224-01

MFDR Date Received

May 1, 2013

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Per Medicare, when multiple OR procedures are performed, the total charges can be listed on the primary procedure code, with all secondary procedure codes listed below it."

Amount in Dispute: \$1,661.52

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The carrier has properly discounted and reimbursed the performed procedures based on Medicare and Texas Guidelines and appropriately denied the procedures that were not adequately documented."

Response Submitted by: The Hartford

SUMMARY OF FINDINGS

Date(s) of Service	Disputed Services	Amount In Dispute	Amount Due
October 25, 2012	Outpatient Hospital Services	\$1,661.52	\$1,595.26

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.403, titled *Hospital Facility Fee Guideline – Outpatient*, sets out the reimbursement guidelines for facility services provided in an outpatient acute care hospital.
3. 28 Texas Administrative Code §134.203, titled *Medical Fee Guideline for Professional Services*, sets out the reimbursement guidelines for professional medical services.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:
 - W1 – WORKERS COMPENSATION SATE FEE SCHEDULE ADJUSTMENT. PAYMENT OF SERVICES ARE INCLUDED IN THE VISIT RATE.

- 217 – NO MAXIMUM ALLOWABLE DEFINED BY FEE GUIDELINES. REIMBURSEMENT MADE BASED ON INSURANCE CARRIER FAIR AND REASONABLE REIMBURSEMENT METHODOLOGY. REDUCED TO FAIR AND REASONABLE.
- 193 – ORIGINAL PAYMENT DECISION IS BEING MAINTAINED. THIS CLAIM WAS PROCESSED PROPERLY THE FIRST TIME.

Issues

1. What is the applicable rule for determining reimbursement for the disputed services?
2. What is the recommended payment amount for the services in dispute?
3. Is the requestor entitled to reimbursement?

Findings

1. This dispute relates to facility services performed in an outpatient hospital setting with reimbursement subject to the provisions of 28 Texas Administrative Code §134.403, which requires that the reimbursement calculation used for establishing the maximum allowable reimbursement (MAR) shall be the Medicare facility specific amount, including outlier payment amounts, determined by applying the most recently adopted and effective Medicare Outpatient Prospective Payment System (OPPS) reimbursement formula and factors as published annually in the Federal Register with the application of minimal modifications as set forth in the rule. Per §134.403(f)(1), the sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by 200 percent, unless a facility or surgical implant provider requests separate reimbursement of implantables. Review of the submitted documentation finds that separate reimbursement for implantables was not requested.
2. Under the Medicare Outpatient Prospective Payment System (OPPS), each billed service is assigned an Ambulatory Payment Classification (APC) based on the procedure code used, the supporting documentation and the other services that appear on the bill. A payment rate is established for each APC. Depending on the services provided, hospitals may be paid for more than one APC per encounter. Payment for ancillary and supportive items and services, including services that are billed without procedure codes, is packaged into payment for the primary service. A full list of APCs is published quarterly in the OPPS final rules which are publicly available through the Centers for Medicare and Medicaid Services (CMS) website. Reimbursement for the disputed services is calculated as follows:
 - Procedure code J1720 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
 - Procedure code C1781 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
 - Procedure code 36415 has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Facility payment for the technical component of this service is calculated according to the Medical Fee Guideline for Professional Services, §134.203(e)(1). The fee listed for this code in the Medicare Clinical Fee Schedule is \$3.00. 125% of this amount is \$3.75
 - Procedure code 80053 has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Facility payment for the technical component of this service is calculated according to the Medical Fee Guideline for Professional Services, §134.203(e)(1). The fee listed for this code in the Medicare Clinical Fee Schedule is \$14.97. 125% of this amount is \$18.71
 - Procedure code 85027 has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Facility payment for the technical component of this service is calculated according to the Medical Fee Guideline for Professional Services, §134.203(e)(1). The fee listed for this code in the Medicare Clinical Fee Schedule is \$9.17. 125% of this amount is \$11.46
 - Procedure code 88304 has a status indicator of X, which denotes ancillary services paid under OPPS with separate APC payment. These services are classified under APC 0343, which, per OPPS Addendum A, has a payment rate of \$36.84. This amount multiplied by 60% yields an unadjusted labor-related amount of \$22.10. This amount multiplied by the annual wage index for this facility of 0.9675 yields an adjusted labor-

related amount of \$21.38. The non-labor related portion is 40% of the APC rate or \$14.74. The sum of the labor and non-labor related amounts is \$36.12 multiplied by 2 units is \$72.24. The cost of these services does not exceed the annual fixed-dollar threshold of \$1,900. The outlier payment amount is \$0. The total Medicare facility specific reimbursement amount for this line is \$72.24. This amount multiplied by 200% yields a MAR of \$144.48.

- Procedure code 49505 has a status indicator of T, which denotes a significant procedure subject to multiple-procedure discounting. The highest paying status T procedure is paid at 100%; all others are paid at 50%. This procedure is paid at 100%. These services are classified under APC 0154, which, per OPSS Addendum A, has a payment rate of \$2,305.60. This amount multiplied by 60% yields an unadjusted labor-related amount of \$1,383.36. This amount multiplied by the annual wage index for this facility of 0.9675 yields an adjusted labor-related amount of \$1,338.40. The non-labor related portion is 40% of the APC rate or \$922.24. The sum of the labor and non-labor related amounts is \$2,260.64. Per Medicare Claims Processing Manual, CMS Publication 100-04, Chapter 4, §10.7.1, if a claim has more than one surgical service line with a status indicator of S or T and any of those lines has a charge of less than \$1.01, then the charges for all S and T lines are summed and the charges are divided across those lines in proportion to their APC payment rate. The new charge amount is used in place of the submitted charge amount in the line-item outlier calculation. This claim has a status indicator S or T line item with a billed charge less than \$1.01; therefore, all S and T line charges are reallocated accordingly. The APC payment for this service of \$2,260.64 divided by the sum of all S and T APC payments of \$3,100.83 gives an APC payment ratio for this line of 0.729044, multiplied by the sum of all S and T line charges of \$4,854.00, yields a new charge amount of \$3,538.78 for the purpose of outlier calculation. Per 42 Code of Federal Regulations §419.43(d) and Medicare Claims Processing Manual, CMS Publication 100-04, Chapter 4, §10.7.1, if the total cost for a service exceeds 1.75 times the OPSS payment and also exceeds the annual fixed-dollar threshold of \$1,900, the outlier payment is 50% of the amount by which the cost exceeds 1.75 times the OPSS payment. Per the OPSS Facility-Specific Impacts file, CMS lists the cost-to-charge ratio for this provider as 0.274. This ratio multiplied by the billed charge of \$3,538.78 yields a cost of \$969.63. The total cost of all packaged items is allocated proportionately across all separately paid OPSS services based on the percentage of the total APC payment. The APC payment for these services of \$2,260.64 divided by the sum of all APC payments is 71.24%. The sum of all packaged costs is \$1,395.26. The allocated portion of packaged costs is \$994.05. This amount added to the service cost yields a total cost of \$1,963.68. The cost of these services exceeds the annual fixed-dollar threshold of \$1,900. The amount by which the cost exceeds 1.75 times the OPSS payment is \$0.00. The total Medicare facility specific reimbursement amount for this line is \$2,260.64. This amount multiplied by 200% yields a MAR of \$4,521.28.
- Procedure code 55520 is a component service of procedure code 49505 performed on the same date. Per Medicare policy, these two codes may not be reported on the same date of service unless a modifier is appended to the component code to differentiate between the services provided. Separate payment for the services billed may be justified if a modifier is used appropriately. The requestor billed the disputed service with an appropriate modifier. Review of the submitted medical documentation finds that modifier 59 is supported; therefore, separate payment is allowed. Procedure code 55520 has a status indicator of T, which denotes a significant procedure subject to multiple-procedure discounting. The highest paying status T procedure is paid at 100%; all others are paid at 50%. This procedure is paid at 50%. These services are classified under APC 0183, which, per OPSS Addendum A, has a payment rate of \$1,652.27. This amount multiplied by 60% yields an unadjusted labor-related amount of \$991.36. This amount multiplied by the annual wage index for this facility of 0.9675 yields an adjusted labor-related amount of \$959.14. The non-labor related portion is 40% of the APC rate or \$660.91. The sum of the labor and non-labor related amounts is \$1,620.05. Per Medicare Claims Processing Manual, CMS Publication 100-04, Chapter 4, §10.7.1, if a claim has more than one surgical service line with a status indicator of S or T and any of those lines has a charge of less than \$1.01, then the charges for all S and T lines are summed and the charges are divided across those lines in proportion to their APC payment rate. The new charge amount is used in place of the submitted charge amount in the line-item outlier calculation. This claim has a status indicator S or T line item with a billed charge less than \$1.01; therefore, all S and T line charges are reallocated accordingly. The APC payment for this service of \$810.03 divided by the sum of all S and T APC payments of \$3,100.83 gives an APC payment ratio for this line of 0.26123, multiplied by the sum of all S and T line charges of \$4,854.00, yields a new charge amount of \$1,268.01 for the purpose of outlier calculation. The cost of these services does not exceed the annual fixed-dollar threshold of \$1,900. The outlier payment amount is \$0. The total Medicare facility specific reimbursement amount for this line, including multiple-procedure discount, is \$810.03. This amount multiplied by 200% yields a MAR of \$1,620.06.
- Procedure code 11200 has a status indicator of T, which denotes a significant procedure subject to multiple-procedure discounting. The highest paying status T procedure is paid at 100%; all others are paid at 50%. This procedure is paid at 50%. These services are classified under APC 0013, which, per OPSS Addendum A, has a payment rate of \$61.51. This amount multiplied by 60% yields an unadjusted labor-related amount of \$36.91. This amount multiplied by the annual wage index for this facility of 0.9675 yields an adjusted

labor-related amount of \$35.71. The non-labor related portion is 40% of the APC rate or \$24.60. The sum of the labor and non-labor related amounts is \$60.31. Per Medicare Claims Processing Manual, CMS Publication 100-04, Chapter 4, §10.7.1, if a claim has more than one surgical service line with a status indicator of S or T and any of those lines has a charge of less than \$1.01, then the charges for all S and T lines are summed and the charges are divided across those lines in proportion to their APC payment rate. The new charge amount is used in place of the submitted charge amount in the line-item outlier calculation. This claim has a status indicator S or T line item with a billed charge less than \$1.01; therefore, all S and T line charges are reallocated accordingly. The APC payment for this service of \$30.16 divided by the sum of all S and T APC payments of \$3,100.83 gives an APC payment ratio for this line of 0.009726, multiplied by the sum of all S and T line charges of \$4,854.00, yields a new charge amount of \$47.21 for the purpose of outlier calculation. The cost of these services does not exceed the annual fixed-dollar threshold of \$1,900. The outlier payment amount is \$0. The total Medicare facility specific reimbursement amount for this line, including multiple-procedure discount, is \$30.16. This amount multiplied by 200% yields a MAR of \$60.32.

- Procedure code J0330 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
 - Procedure code J0690 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
 - Procedure code J1100 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
 - Procedure code J2001 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
 - Procedure code J2175 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
 - Procedure code J2250 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
 - Procedure code J2405 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
 - Procedure code J3010 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
3. The total allowable reimbursement for the services in dispute is \$6,380.06. This amount less the amount previously paid by the insurance carrier of \$4,784.80 leaves an amount due to the requestor of \$1,595.26. This amount is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is \$1,595.26.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of \$1,595.26, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

Authorized Signature

Signature

Medical Fee Dispute Resolution Officer

September 9, 2013
Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, 37 *Texas Register* 3833, **applicable to disputes filed on or after June 1, 2012.**

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.